



November 20, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Centers for Medicare & Medicaid Services: Innovation Center New Direction¹

Dear Administrator Verma:

On behalf of the Board of Directors of the Community Oncology Alliance ("COA"), I am submitting this comment letter on the Request for Information ("RFI") released by the Centers for Medicare & Medicaid Services Innovation Center ("Innovation Center") regarding a new direction.

About COA and Our Work on Oncology Payment Reform

The Community Oncology Alliance ("COA") is a non-profit organization dedicated to advocating for community oncology practices and, most importantly, the patients they serve. COA is the only organization dedicated solely to independent community oncology where the majority of Americans with cancer are treated. The mission of COA is to ensure that cancer patients receive quality, affordable, and accessible cancer care in their own communities. For more than fifteen (15) years, COA has built a national grassroots network of community oncology practices to advocate for public policies that benefit cancer patients. Individuals from all perspectives of the cancer care delivery team – oncologists, administrators, pharmacists, mid-level providers, oncology nurses, patients, and survivors – volunteer their time on a regular basis to lead COA and serve on its committees.

As the front-line providers for the majority of Americans with cancer, COA members understand the numerous challenges of fulfilling CMS regulations, policies, and procedures relating to cancer care. For over six (6) years, community oncology practices have been working tirelessly to make meaningful, effective oncology payment reform a reality. In particular, practices were early participants in the Innovation Center's "COME HOME" demonstration project, which exemplified not only excellence in cancer care delivery, but also at a markedly reduced cost to both payer and patient, compared to similar care in the hospital outpatient setting. On the private payer side, community oncology practices have been actively implementing oncology payer reform models with Aetna, UnitedHealthcare, Priority Health, and numerous Blue Cross Blue Shield Association insurers across the country.

COA is currently fully invested in the Innovation Center's Oncology Care Model ("OCM") and has developed a cooperative network, hosting close to eighty percent (80%) of the OCM participants. The OCM model is very similar in construct to COA's Oncology Medical Home ("OMH") but unfortunately has cumbersome, and often burdensome, metrics and other requirements. Participation in the OCM is helping to shape our work on what we call the "OCM 2.0," an advanced OCM model, that we will discuss in more detail in this letter.

¹ <https://innovation.cms.gov/Files/x/newdirection-rfi.pdf>

Just last month, COA convened a two-day meeting outside of DC that brought together over two hundred (200) providers, payers, employers, CMS/CMMI personnel, and industry to discuss progress on the OCM, details of the OCM 2.0, and updates on private payer and employer models of cancer care. As can be clearly seen, community oncology and COA are leading the progress in tackling the increasing costs of cancer care. In doing so, we are using data, market facts, and the real-world medical experience of physicians, nurses, administrators, pharmacists, and others on the front lines of cancer care to craft viable, patient-centric solutions.

Comments on a New Direction for the Innovation Center

We appreciate the opportunity to offer our insights on the new direction for the Innovation Center. COA has supported the early efforts of the Innovation Center, including working closely with Innovation Center leadership on the development of what ultimately became the OCM. We have also heard from thousands of physicians around the country, some of whom are not oncologists but share COA's values on payment reform.

In the RFI, CMS wrote that, *"Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses."* As such, we draw the following input based on our extensive experience working on Medicare and private payer oncology payment reform models and, very specifically, based on our experiences with the COME HOME and OCM projects.

Overall Perspective on Reorienting the Innovation Center

Before commenting specifically on the Guiding Principles and New Model Development outlined by the Innovation Center in the RFI, we would like to outline some "high-level" perspectives that we believe are critical in reorienting the Innovation Center. We emphasize the word "critical" if the Innovation Center is going to be a real, substantive "incubator" for developing new Medicare care and payment models that will not just sound good in promotion, but actually change Medicare for the better.

What follows are our "high-level" perspectives.

In general, the Innovation Center needs to be nimbler in implementing models that are simpler, less grandiose, and provide quicker feedback. Real world payment reform will not be achieved with large, costly, and timely models that sound good on paper but are not practical to implement in our nation's existing health care system. This is part "science" and part "art," as private payers have approached these models.

In concert with this last point, entry into new models needs to be vastly simplified. For example, the application process for the OCM was so burdensome that practices had to hire consultants to complete the OCM applications. These consultants were needed to interpret and translate the requirements (as well as other aspects of the model) which have added expense, burden, and restricted enthusiasm to participate in the model. Is that "innovation" or government bureaucracy?

The Innovation Center needs to be guided more by the input of providers with real world experience, rather than Innovation Center staff, contracted organizations, and physicians that have minimal involvement in patient care. The Innovation Center should be centered around expediting the best ideas from providers rather than forcing models on providers – especially mandatory models, such as last year's *Part B Drug Payment Model*. It is also critical to have patients involved in this process.

No model should ever be mandatory and national, like the case with the *Part B Drug Payment Model*, and the Innovation Center should never be used to bypass Congress in changing Medicare law, as was also the case with the *Part B Drug Payment Model*. At all costs, patients (Medicare beneficiaries and others) need to be protected and not subject to research with proper safeguards and information.

The Innovation Center needs to be less prescriptive in implementing models and require far less complex implementation. Let providers be providers in implementing models. The Innovation Center should not dictate

how providers practice medicine. It should establish clear model objectives, in concert with providers and measurement endpoints, then let providers practice medicine and be measured.

Measures need to be simplified and more “outcomes” oriented rather than “process” oriented, as CMS has already identified in its “Meaningful Measures” initiative. The Innovation Center should also be more flexible with choosing the most appropriate measures available, not simply those that have been “validated.” To date, this has been a challenge. The Innovation Center should also not place burdensome requirements on providers to manually collect measures.

In concert with the last point, measures should not be viewed as a stick but as a tool to improve practice effectiveness and efficiency. As such, measure reporting by the Innovation Center back to practices needs to be faster, timelier, and in such a manner and format as to engender change for the better.

We want to underscore that we are big believers in the Innovation Center and have enjoyed working with staff on the OCM. **We are not trying to be unduly critical of the Innovation Center, but strongly believe that it needs a course correction to make it a viable incubator for lasting care and payment reform.**

What follows is our specific input on the Guiding Principles and Recommendations on New Model Development.

Guiding Principles

We offer thoughts on the Guiding Principles based on COA’s work over the years with community-based oncologists, as well as recent experience with the OCM.

1. Choice and Competition in the Market – Promote competition based on quality, outcomes, and costs.

COA has long supported the notion that patient choice and competition in the market lead to better care, particularly for cancer patients. This is why one of our principal areas of concern is the rapid rate of consolidation in the market, especially among oncologists. COA has performed numerous analyses around the increased cost of care related to such consolidation and found that:

- A. An average of 5.8 community based cancer teams have been acquired by hospitals, PER MONTH, since 2010.²
- B. An average of 3.6 community cancer centers, PER MONTH, have closed due to the lack of sustainable reimbursement for their services.³
- C. Chemotherapy delivered in the hospital outpatient setting is nearly sixty percent (60%), or \$90,144 per year, more expensive than the same treatment delivered in independent, community oncology practices. The biggest drivers for the cost differential were the cost of chemotherapy, which was seventy-one percent (71%) higher, or \$3,510, more expensive per month in the hospital setting (\$8,443 vs. \$4,933), and the cost of physician visits, which were three-hundred and thirty-three percent (333%) higher, or \$2,551, more expensive in the hospital setting than in the community practices (\$3,316 vs. \$765).⁴
- A. ED visits by cancer patients following chemotherapy were also higher in the hospital outpatient setting than the community practices. Within seventy-two (72) hours of chemotherapy, they were nearly forty percent (40%) higher in the hospital setting (3.6% vs. 2.6%), and within ten (10) days of chemotherapy, they were twenty-four percent (24%) higher in the hospital setting (9.8% vs. 7.9%).⁵
- B. The shift of cancer care from independent, community oncology practices is costing Medicare

² 2016 Community Oncology Alliance Practice Impact Report. Community Oncology Alliance. <https://www.communityoncology.org/2016-coa-practice-impact-report/>

³ Ibid.

⁴ The Value of Community Oncology. Gordan and Blazer. https://www.communityoncology.org/wp-content/uploads/2017/09/Site-of-Care-Cost-Analysis-White-Paper_9.25.17.pdf

⁵ Ibid.

enormously. In 2014 alone, Medicare paid \$2 billion more for cancer care delivered in the hospital setting than in community oncology practices.⁶

As a result, COA was extremely pleased to see the development of a specialty payment model, such as the OCM, which offers a pathway to market competition on the basis of value.

We strongly recommend that the Innovation Center test models that incent medical care towards the lower cost setting, something that private payers are pursuing. These models can include varying patients' copayments, so they are not penalized for seeking the higher cost setting but are rewarded for finding the lower cost in the physician office setting versus the higher cost hospital outpatient setting.

2. *Provider Choice and Incentives – Focus on voluntary models, with defined and reasonable control groups or comparison populations to the extent possible, and reduce burdensome requirements and unnecessary regulations to allow physicians and other providers to focus on providing high-quality health care to their patients. Give beneficiaries and health care providers the tools and information they need to make decisions that work best for them.*

This guiding principle is just as important as the first one; the two must exist together in order for any model to achieve its desired success and scale. In our experience with the OCM, we have noted that an unintended consequence of the desire to improve claims-based risk adjustment and focus on creating oncology drug “payment bundles” is that the burden on providers to participate in the model has become quite challenging, so much so that Medicare funds intended for better care coordination have now been largely used to hire staff for data extraction, data entry, and non-clinical activities.

COA supports a voluntary support network that is free and open to all OCM participants. As noted previously, we currently host a peer-to-peer learning and support network for the OCM, in which approximately eighty percent (80%) of the OCM participants are actively involved. Instructive to re-focusing the Innovation Center, it is important to note the following burdensome requirements of the OCM:

- A. **Clinical Registry Data Reporting:** Practices have repeatedly stated that they have issues with collecting, validating, and submitting the twenty-seven (27) different clinical elements, in addition to the thirteen (13) quality measures, required for the OCM. Moreover, the third party through which data is submitted often has technical glitches, thus further delaying submissions and frustrating practices. As a result, COA has proposed to either narrow the field of required elements or continue to delay reporting. This is especially important as a Spring 2018 submission deadline looms at the same time OCM participants will receive reconciliation data regarding their performance. Approximately a third of the OCM practices have less than ten (10) physicians. As a result, the burdens of reporting, as well as capturing data accurately, have been overwhelming.
- B. **Quality Measure Reporting:** In a similar vein, we have concerns regarding the appropriateness and burdens of existing OCM quality measure reporting, which is illustrative of not only how the OCM needs to be modified but how quality measurement development and reporting needs to be streamlined and more collaborative with providers. Our specific concerns regarding the OCM quality measure report are as follows:
 - **Patients in Hospice Three (3) Days or More:** This is a low bar and does not promote improvement to more appropriate utilization of this important service.
 - **Patient Reported Experience:** We agree that patient and family feedback regarding their cancer care is valuable in the effort to improve quality. However, to do this effectively, the feedback needs to be current, as close to real time as possible, and actionable at the physician level. Neither of these criteria are met with the OCM patient survey. Although we suggested use of

⁶ Cost Drivers of Cancer Care. Milliman. <https://www.communityoncology.org/pdfs/Trends-in-Cancer-Costs-White-Paper-FINAL-20160403.pdf>

the COA patient experience survey – which is totally open-source and free, available in paper and digital formats, available in five (5) languages, is updated in real time, and has over one-hundred thousand (100,000) administrations – OCM staff ignored our offer. Instead, OCM opted for a survey that was twice as long, paper only, and has inferior reporting and benchmarking ability.

- Pain Intensity Quantified: Pain can vary in severity and intensity by the hour in a patient’s cancer care journey. A measure of intensity is only good for that hour time period. A plan for pain is important, a different measure, but measuring intensity is meaningless.
- Screening for Depression and Follow-Up: Similar to the above, cancer patients often have moments of depression – with some lasting longer than others. We have asked many cancer patients, and cancer care advocacy organizations for their feedback on this measure. The common response is they “expect” to have moments of depression but rarely do they want intervention. They view it as simply a part of the journey. A more meaningful measure would be screening for distress and intervention when appropriate.
- Current Medications in Medical Record: This measure is presented as a Yes/No measure. Unfortunately, it is not that simple in managing cancer patients. Patients often forget to report all of their medications and there are wide variations in compliance rates for taking them. It is virtually impossible to implement such a measure in any meaningful way for cancer care.

Our point in listing these very specific examples to the OCM, is that measures need to be developed by providers, as well as more realistic in collection and reporting.

- C. Misalignment of Alternative Payment Models with Aspects of MACRA/MIPS: Currently, all OCM participants are able to have their quality measures qualify for the quality and clinical improvement activities in the Merit Based Incentive Payments System (“MIPS”), but they are still required to participate in, at minimum, the Advancing Care Information portion of MIPS. This is a redundant requirement considering six (6) of the fifteen (15) CMS Advancing Care Information measures are included in the OCM, specifically:

- Clinical Data Registry Reporting: OCM participants are required to report twenty-seven (27) clinical data elements under the OCM.
- Clinical Information Reconciliation: Medications and problems are required under the OCM Institute of Medicine (“IOM”) care plan and reconciliation of problems is assisted by the Innovation Center.
- E-Prescribing: OCM participants are required to use a Certified EHR and this certification requires e-prescribing.
- Provide Patient Access: Beneficiary access to their medical record is required under the OCM and, because CEHRT technology is required, the OCM participant must also have a patient portal.
- Request/Accept Summary of Care: A care plan is required under Transformation Requirements of the OCM.
- Secure Messaging: Also required under CEHRT, and CEHRT is required under the OCM.

We do want to acknowledge and applaud the willingness of Innovation Center staff to work with organizations and OCM participants to overcome some of these challenges. Unfortunately, any suggested changes to model design are difficult to advance and, as a result, we remain concerned that the guiding principle outlined in this RFI will be difficult to achieve without alterations to the current program, as well as an acknowledgment that future models must align around value to beneficiaries and providers. Simply put, if the burdens for participating in the model far exceed the benefits of traditional fee-for-service, then it is no question that alternative payment models will be poorly adopted and differentially will only appeal to large institutions with the financial resources to support the burdensome requirements, if at all.

3. *Patient-Centered Care – Empower beneficiaries, their families, and caregivers to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care across the care*

continuum.

COA agrees that this principle is important to all payment models, particularly any new programs from the Innovation Center. We have been working to place patients at the center of their cancer care through the development of the OMH.

The patient-centered OMH initiative began five (5) years ago, and most of the principles from the OMH can be found in the OCM. The foundation of the OMH included five (5) separate and different collaboratives for measures, implementation, data and reporting, payment reform, and accreditation.

The current OCM model does feature elements of beneficiary engagement. However, as we have been working with OCM participants, we have found that the process of engaging beneficiaries has, unfortunately, focused too heavily on requirements derived from recommendations from the IOM. This is problematic because the IOM recommendations were never intended to be applied to a payment model.

With that in mind, we propose that the following elements of patient-centered care be incorporated into the OCM. Once again, the following recommendations are specific to the OCM but illustrative of our general thinking relative to Innovation Center models:

- A. Incorporation of shared decision-making elements into current models, including the OCM.
- B. Eliminate “clawbacks” for beneficiaries who choose to enter into Medicare Advantage plans in the midst of an OCM episode.
- C. Adjust the design of the model so that hospice is promoted and any disincentives are removed. (Payments for transforming cancer care are currently discontinued when the patient is admitted to hospice.)
- D. Similarly, allowances for access to state-of-the-art treatments through industry-sponsored clinical trials need to be addressed. Participants should not perceive clinical trial participation as a disincentive to be successful in the model.

4. *Benefit Design and Price Transparency – Use data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes.*

COA firmly endorses this principle. We have been working with experts from the University of Michigan’s Center for Value-Based Insurance Design (“V-BID”) to encourage the use of high-value services and drugs in cancer care while removing as many obstacles as possible so that cancer patients receive the right care, at the right time, and in a treatment location that is local and convenient to them. Price transparency, particularly in Medicare, we believe would be a welcome way for beneficiaries to engage in making decisions around non-emergent areas of clinical care. For example, in our experience working with cancer patients, very few understand the concepts around copayments, deductibles, etc. Allowing for price transparency around part D medications, as well as a more thorough understanding of the details in the Explanation of Benefits (“EOB”) that beneficiaries receive, would be a valuable addition. In the current OCM model, there is a component of financial counseling that is expected, and it has been difficult to try and offer beneficiaries a sense of their total cost of care. As a result, we recommend that the Innovation Center needs to address transparency in a more realistic manner.

5. *Transparent Model Design and Evaluation – Draw on partnerships and collaborations with public stakeholders and harness ideas from a broad range of organizations and individuals across the country.*

COA absolutely endorses this principle and has subscribed to it in our work on a potential future model related to oncology, which we refer to as the “OCM 2.0.” We have been developing model principles in a transparent partnership with:

- A. Private Payers: Approximately fifteen (15) different national and regional payers have been working with COA, as well as attending our bi-annual Payer Exchange Summit on Oncology Payment Reform.

- B. Physicians: We have worked with physicians of all practice types and tried to understand what the barriers are to enter into value-based arrangements, as well as the burdens in existing alternative payment models. We have incorporated that feedback into the development of the OCM 2.0.
- C. Patients: The most important group that we have worked with on the OCM 2.0 has been patients, including patients who are actively receiving cancer treatments, patients who have survived beyond their diagnoses of cancer, and caregivers (e.g., family, friends). The feedback we have received has largely centered around transparency among providers, patients, and payers, and a real collaborative model where shared decision-making and patient-centeredness is of critical importance to any model. In the OCM 2.0, we have incorporated such design elements.
- D. Life Sciences: A critical stakeholder in the efforts to combat cancer are drug and device manufacturers. We have also included them as important voices in the design of the OCM 2.0 model; in particular, around ways to deal with the financial toxicity of cancer care while also encouraging innovation.

COA encourages CMS to consider how to apply these transparent model designs and evaluations to existing and future Innovation Center models. For example, the OCM has multiple layers of calculations within the model and a lack of clarity in aspects of the methodology and challenges to the quality of the clinical data that is being submitted to CMS. We have heard this feedback from all sizes and types of participants in the model. Any model that will be different than the current reimbursement processes will need to be clearly explained, likely multiple times, and with clear examples that smaller and larger participants can follow.

6. *Small Scale Testing – Test smaller scale models that may be scaled if they meet the requirements for expansion under 1115 A(c) of the Affordable Care Act (the Act). Focus on key payment interventions rather than on specific devices or equipment.*

COA supports this principle, in particular, as it applies to the heterogeneous nature of health care practices and professionals in America, especially in cancer care. COA works with independent oncologists across the country and the ability for one payment model to be “one-size-fits-all” simply does not work. This is evidenced by the fact that in the OCM, smaller practices struggle with the numerous program requirements, whereas larger practices are able to subsidize the infrastructure costs to fulfill program requirements. Small-scale testing would likely reveal which models are best suited for particular physician practice sizes, etc., as well as help generate enthusiasm and willingness to participate by a large pool of practices.

Recommendations for New Model Development

COA offers the following thoughts for new model development, which is based on our work in the current OCM and on our future payment model design of the OCM 2.0:

1. *Increased Participation in Advanced Alternative Payment Models (APMs):*

COA enthusiastically agrees that this focus area, along with increased specialty models (focus area #3), are two of our organization’s top priorities. It is incredibly frustrating for clinicians to want to make the leap into better care and find that their opportunities for participation in an alternative payment model are limited.

The recent OCM has been heralded, rightfully so, as one of the few specialty payment models that can appeal to independent and hospital-employed physicians alike, regardless of geography, practice size, etc. Unfortunately, there was only one opportunity to participate in the model. We urge CMS to honor this first focus area and consider opening up existing models that offer pathways to alternative payment models while also adding new APMs.

We caution the Innovation Center, however, that in the desire to add Advanced APMs, it is important to also align aspects of the “advanced” qualities of payment models, such as the limits in downside risk. For example, the current OCM model has a twenty percent (20%) downside risk threshold, which far exceeds any other Innovation Center payment model. Such a great disparity simply discourages participation. A suggestion

would be to ensure consistent downside risk limits for models, as well as consideration of technical assistance to help providers who are interested in Advanced APMs but might lack an understanding of how best to navigate such a transition. We strongly recommend this based on our ongoing support of the OCM and the significant interest in technical support to deal with program requirements.

A technical assistance program might also help to stem the tide of physician consolidation, as many physicians are looking for ways to survive independently but feel overwhelmed by the many programmatic requirements and perceived barriers.

2. *Consumer-Directed Care and Market-Based Innovation Models:*

COA has taken a market-based approach in our work developing the OCM 2.0; in particular, we have reached out to employers and employer health collaboratives in regions across the country and heard that they are open to innovation that can appeal to their unique local market needs. For example, in Florida, we are working with a coalition of employers to ensure that cancer patients have access to high-quality care, including second opinions, access to remote care, and better coordination between specialties. All of this meets the needs of patients who express a desire to continue their work while receiving cancer care. Consumer-directed care is also a feature of the OCM 2.0, with the potential for patient-directed selection into cancer care.

In addition, we are looking at ways to incorporate V-BID into our payment model. For example, we would ensure that services related to secondary prevention of cancer would not have a copay, to encourage cancer survivors to make sure they are receiving proper screenings and surveillance. We are also exploring the ability to use V-BID with respect to drug therapy choices, all without constraining the autonomy of physicians or interfering with the physician-patient relationship.

Finally, we express some caution: As we have worked over the years with cancer patients, we also want to make sure that any vulnerable patients, who might lack health literacy or have limited means of communication, are protected from unintended consequences in a consumer-directed model. These protections might include additional efforts for outreach around consumer participation in a model, as well as understanding if disparities are unintentionally exacerbated through robust model evaluations.

3. *Physician Specialty Models:*

As we mentioned above, physician specialty models are a high priority for COA. We note with great interest the specific mention by CMS around cancer care:

“For cancer care in particular, a model could test full prepayment for Medicare and Medicaid beneficiaries, with care provided in collaborative networks, possibly incorporating elements from the existing Oncology Care Model.”

COA applauds the ambitious aspects of the suggested model and we would welcome further dialogue with CMS to explore this particular interest. We also have some feedback on problematic aspects of the OCM which could complicate a full prepayment model:

- A. Complex Payment Methodology and Delayed Access to Claims Data: This makes it extremely difficult to know how an oncology practice might be performing clinically and financially with enough time to make changes to avoid significant financial losses.
- B. Problematic Aspects of “Clawback” Payments: The OCM includes a provision for clawback payments when patients enrolled in the OCM choose to enroll in Medicare Advantage. Such payments are complex and unpredictable and create chaos while trying to succeed in an innovative model.
- C. Claims-Based Risk Adjustment: The integration of personalized medicine in cancer care highlights the consequences of a lack of a robust risk adjustment. Currently, cancer staging is not incorporated into claims data. The advent of ICD-10 coding has helped, but there are still aspects of genetic markers, etc., that have implications on risk adjustment, which are not easily incorporated into claims. The

OCM model has a novel clinical registry but, as we mentioned previously, the execution of the registry has been problematic, and it is not clear how its elements will be used.

In developing the OCM 2.0, we have dealt with some of the above challenges by trying to limit the types of cancers included in the model – with a thought towards adding additional cancers in the OCM 3.0, 4.0, etc. – and to also use additional sources of data for risk adjustment, such as existing state and local cancer registries, and to limit clinical registry elements. We have also borrowed from important aspects of the OCM, such as insemination, a mechanism to deal with outliers in a payment model. Finally, we support the Physician-Focused Technical Advisory Committee (“PTAC”) and have submitted a Letter of Intent (“LOI”) to the PTACT expressing an interest in submitting a full proposal. We hope that the models promulgated by PTAC will be facilitated through a process that does not delay the opportunities for physicians to enroll in proposed models.

4. Prescription Drug Models:

COA supports prescription drug payment models that better align incentives and engage beneficiaries as consumers of their care while controlling costs. Models that contemplate novel arrangements between plans, pharmaceutical manufacturers, and stakeholders across the supply chain, including, but not limited to innovative value-based purchasing arrangements, as well as models that would increase drug pricing competition while protecting beneficiaries’ access to drugs, are very important. We would hope that regulatory barriers related to Medicaid best price, average sales price issues, patient assistance, etc., be waived in facilitating testing of value-based drug models, and other potential threats to innovative drug models, might be addressed in these models.

5. Medicare Advantage Innovation Models:

COA has always believed that the options in Medicare Advantage offer strong competition among plans and, thus, a benefit overall for the Medicare beneficiaries who select to enroll in such programs. We support the notion of innovation between fee-for-service and Medicare Advantage and have featured aspects of this in our own OCM 2.0 design. We echo the input of others who advocate for more supportive supplemental benefits, as this is a particular aspect of financial toxicity in cancer care.

Additionally, COA has long understood the complex intersection between social determinants of health and the ability to battle cancer. Recent important changes in the Medicare Physician Fee Schedule will allow for broader telehealth services within Medicare Advantage, which we applaud. However, we encourage CMS to explore supplemental benefits, such as transportation and, in limited scale testing, housing.

6. State-Based and Local Innovation, including Medicaid-Focused Models:

COA agrees firmly with CMS that states play a critical role in innovation and delivery of high-quality care. We hope that innovation can lead to successful state-led models that improve the lives of cancer patients while also allowing for robust independent physician participation. As health care providers and states work with CMS to develop state-based plans and local innovation initiatives to test new models, we encourage CMS to look to organizations, like COA, to mobilize oncologists to also have a seat at the table.

7. Mental and Behavioral Health Models:

COA has found that in the care of cancer patients, mental and behavioral health needs sometime do not receive the attention they deserve. We encourage CMS to explore how to better integrate behavioral health services into oncology settings and, to that end, we support the work in the OCM that has emphasized depression screening, as well as specialty care coordination.

Behavioral health financing, particularly in Medicaid, is another barrier that de-emphasizes the need for physicians to address behavioral issues while dealing with physical issues, such as cancer. New payment models should try to integrate services and explore financing which rewards such integration. In our

conversations around the OCM 2.0, we are trying to identify best practices in such areas and will share those with interested parties at CMS.

8. *Program Integrity:*

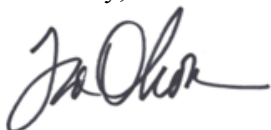
COA supports ways to reduce fraud, waste, and abuse and improve program integrity while also being sensitive to the additional workload created for physicians to maintain such integrity.

Conclusion

COA appreciates the opportunity to comment on the future direction of the Innovation Center. We look forward to working with CMS to accentuate the patient-centered policies that will improve the quality, cost, and delivery of health care in this country.

I can be contacted through the COA offices if there are any questions about this letter.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Ted Okon', with a stylized, cursive script.

Ted Okon
Executive Director